Social Development Paper
FUNDING THE FIGHT AGAINST HIV/AIDS

Responding to the HIV/AIDS Pandemic in the Department of Social Development

Jolene Adams
Marritt Claassens
Lulama Dikweni
Judith Streak

Budget Information Service—Idasa
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Contents

Introduction

The introduction to this paper describes the role of the DSD in combating HIV/AIDS, the purpose of this paper and the methodology we used. The rest of the paper is divided into 3 parts:

- Part I describes the role of the Social Assistance and Social Welfare programmes in the NIP.
- Part II discusses the role of the PRP in the NIP.
- Part III examines whether the budgetary allocations to social security factor in the impact of HIV/AIDS into their budgets.

A. The role of DSD in combating HIV/AIDS

By 2010 South Africa will have close to 2.2 million orphans as a direct result of HIV/AIDS. Many of those affected by HIV/AIDS—both adults and children—will become dependent on the state to provide them with care (income and shelter). In the constitution of South Africa (section 27) (Government of South Africa, 1996a) vulnerable groups in society, or those unable to take care of their own basic needs or families, are guaranteed the right to social assistance. Constitutionally the Department of Social Development (DSD) is therefore responsible for the financial, emotional and physical care of those made vulnerable by the disease.

The DSD delivers social welfare services to the poor and vulnerable groups through the following programmes:

- **Social Assistance**: finances private sector welfare institutions such as homes for the disabled, orphaned children and the aged

- **Social Welfare Services**: finances public sector welfare programmes as above;

- **Social Development or Poverty Relief Programme (PRP):** facilitates social change based on community initiatives. This programme aims to provide income support through income generating projects to those groups of poor people not covered by the current social security net;

- **Social Security**: payment of grants for social security including pensions for the aged, child support for poor children and the severely disabled.

The DSD identified the following implications of the impact of HIV/AIDS on the delivery of their services:

- Fewer people to care for children and older persons
- Increase in orphaned children in need of care
- Increased financial burden on households as a result of increased poverty
- Increased vulnerability of women
- Increase of infected and affected youth

- Decrease of welfare service delivery due to the impact of HIV/AIDS on workers in the welfare sector

Therefore, it is important to know:

- DSD's response to the HIV/AIDS pandemic as articulated within policy documents
- How DSD plans to redirect funding resources to specific HIV/AIDS programmes
- What mechanisms are in place for the distribution of funds (national and provincial)

B. Purpose of paper

This research paper covers the government's response to HIV/AIDS in the social development sector, focusing on the funding mechanisms used in those interventions. The paper aims to generate baseline information on expenditure trends, policy and implementation mechanisms affecting the fight against HIV/AIDS in the DSD. We focus on the three main programmes in the department: Social Assistance and Social Welfare Services, the Poverty Relief Programme, and Social Security.

Even though the DSD's role as stipulated in the National Integrated Plan (NIP) is to develop home based care for infected and affected people, this research includes social security allocations within provincial welfare departments for several reasons. Firstly, funding from national level through the NIP is for 3 years only. Provinces will therefore have to start incorporating the impact of HIV/AIDS into their budgets. Secondly, social security comprises more than 90% of provincial welfare budgets (Adams, 2001). It would therefore be short-sighted to ignore the impact of HIV/AIDS on this programme. Thirdly, at a special MINMEC meeting on poverty relief programmes, 24th March 2000, it was decided that PRP would focus on the provision of food security and counselling to support communities affected and infected with HIV/AIDS.

In order to achieve the above aim, this paper pursues the following objectives:

- To describe government's broad HIV/AIDS policy objectives (mitigation and prevention);
- To identify and describe the implementation structures;
- To identify how much money has been targeted for HIV/AIDS expenditure (both within mainstream and HIV/AIDS-specific programmes);
- To look at how financial resources for HIV/AIDS are allocated within DSD (budgeting decisions and priorities).
- To look at what mechanisms are used to transfer these resources to spending agencies (the institutional structures). For example how Independent Development Trust (IDT) transfers poverty relief funds; Conditional grants and Block grants.

C. Methodology

In order to paint as comprehensive a picture as possible, the authors concentrated on collating relevant information from mainly government sources at national and provincial levels. Initially all 9 provinces were included as data collection sources.

Although contact was made with all nine provinces, information was only received from a few. In the case of those responsible for the implementation of CHBC, the researcher was

only able to collect information from the Eastern Cape, Northern Province, North West and Mpumalanga, despite several attempts to obtain responses from the remaining provinces. In some cases follow-up questions and clarifications had to be asked. Responses varied for the different programmes (social security, CHBC, PRP).

A structured self-reporting questionnaire was used, which was either administered face-to-face or telephonically, or self-administered by the relevant respondents. However, individual researchers were allowed to add or remove questions from the questionnaire depending on the programme they were researching. Appendix A contains a list of the standardised questions and further description of the research process.

D. Problems experienced in the research process

We were not able to collect data for all the provinces. In the few cases where responses were received, not all questions were answered. This can be ascribed to the relative newness of the CHBC component and particularly the role of the DSD as defined in the National Integrated Plan. The HIV/AIDS Directorate at national level was established in April 2001 and the provincial HIV/AIDS coordinators hired shortly thereafter, making it difficult to obtain information since many of the programmes were still in the planning/implementation phase.

Some of the difficulties experienced by the research team are discussed below:

1. Early planning stages of CHBC

At a strategic CHBC workshop held on 17-19 June 2001, in Johannesburg, it was decided that provincial and national HIV/AIDS co-ordinators would examine their respective provincial budgets to establish what can be made available to HIV/AIDS programmes in addition to the HIV/AIDS conditional grant. Provinces were therefore not in a position to indicate how much they have allocated in addition to the HIV/AIDS grants.

At the same workshop it was provisionally decided that DSDs should only submit their provincial situational analysis reports (i.e. the number of existing CHBC in the respective provinces) at the end of August 2001. Furthermore, the situational analyses were not required to be HIV/AIDS specific but could also include home and community based care programmes etc. that cares for the aged, disabled etc. It is therefore not possible to pinpoint what percentage of the CHBC programme focuses exclusively on HIV/AIDS.

2. First year HIV/AIDS included as PRP objective

It is the first year (2001) that the PRP introduced and interfaced HIV/AIDS as part of its objectives. Several provinces are still in the process of workshopping their plans (i.e. establishing their poverty relief projects and how much to allocate to HIV/AIDS). It was therefore difficult to obtain the required information.

Furthermore, the HIV/AIDS allocations in the PRP are not directly aimed at HIV/AIDS infected people or their families. Magisterial districts with high infection rates were identified as possible sites for establishing projects. The only link between the HIV/AIDS specific PRP and HIV/AIDS infected and affected people is therefore geographical location.

3. Difficulty researching social security without AIDS specific data

Data on the projected number of beneficiaries of the five main grants were not available. Hence, the data on the number of payments were used to track changes in demand for the five main grants over time.

It is not possible to be 100% certain whether provinces are budgeting for HIV impacts using time series analysis. And in the absence of disclosure regarding HIV/AIDS status and AIDS specific data, broad trends in budget allocations are the only means available to establish whether the impact of HIV/AIDS is incorporated in establishing budgets.

Furthermore, a Committee for Comprehensive Social Security in South Africa was established in May 2000 to develop comprehensive framework and policy options for social security focusing both on contributory and non-contributory schemes. The Committee's work is overseen by an Inter-Ministerial Committee consisting of Health, Social Development, Transport, Labour and Treasury (National Treasury, 2001a). The findings of the committee, if accepted by Cabinet, could have a significant impact on the kind of assistance available to the poor and HIV/AIDS infected and affected people. The Committee was expected to submit their findings to Cabinet by the end of July 2001.[1] The terms of reference for the Committee are as follows:

- The Committee must investigate alternative options indicating an envisaged future social security system. These should be extensively motivated and viable.

- Options for immediate practical implementation need to be practical and focused on immediate needs, based on the current level of South Africa's development and affordability.

- The Committee must provide information on the viability and significant negative or positive implications linked to any options considered.

Thus the upcoming results of the Committee could not be included in this study but will certainly impact on how the DSD funds social security programmes.

The factors listed above severely impacted on the quality and availability of the information the researchers were able to collect. Since the CHBC programme is still in the set-up phase, it is difficult to draw substantial conclusions or make effective recommendations.

[1] By our understanding, the Committee's report has yet to be released.

Part I: The role of the Social Assistance and Social Welfare programmes in the NIP

1. Key Strategies for Managing the Pandemic in the DSD

1.1 HIV/AIDS/STD Strategic Plan for Children Infected and Affected by HIV/AIDS 2000-2005

In response to the HIV/AIDS crisis, the DSD, in conjunction with the Departments of Health and Education, designed the HIV/AIDS/STD Strategic Plan (HIVSP) for South Africa 2000-2005 (Government of South Africa, 2000 b). The strategy consists of four major components:

1. Prevention
2. Care and Support,
3. Research, Monitoring and Evaluation, and
4. Human and Legal Rights.

The DSD has two functions allocated to it within the national strategy, namely:

- To develop alternative models of care and to design marketing strategies to promote acceptance from communities around new forms of care; and
- To destigmatise those suffering from HIV/AIDS

Additional functions of DSD include:

- To investigate legislation to ensure legal recognition or status for child headed-households; and
- To encourage/subsidise private fostering of children.

According to Streak (2001) the overall purpose of the HIVSP is to guide the country's response to the pandemic. The HISVP document is based on the assumption that government departments, stakeholders, etc. will use the document as a guide to develop their own strategic and operational plans.

1.2 National Integrated Plan for Children & Youth Infected and Affected by HIV/AIDS

The National Integrated Plan for Children and Youth Infected and Affected by HIV/AIDS (NIP) was implemented in 2000. NIP is the national government's key strategy for managing the spread and impact of the disease. The core components of the NIP are its integrated approach and its emphasis upon the identification and provision of services for children affected by HIV/AIDS, particularly orphans. The position of women in society, especially their role as primary caregivers of children, and the relationship between men and women in society are also components of the Plan.

Of the three NIP programmes, DSD is concerned with the Community and Home Based Care and Support Programme (CHBC). The vision is for non governmental organisations

(NGOs), faith-based organisations (FBOs) and representatives in the community to work together to provide medical, social and psychological services to infected people and families affected by HIV/AIDS in their households and communities.

1.3 Community and Home Based Care and Support Programme

The White Paper on Welfare (1997) articulates a shift towards developmental social welfare that fosters an enabling environment for individuals to be self-sufficient. This replaces a model of curative and institutional care that is said to increase dependency on the state. Self-reliance is one of the main pillars of developmental welfare. The approach assumes that individuals and communities are best able to take care of themselves. Taking care of vulnerable children and adults would therefore have to take place within the "community care" paradigm.

In February 2001 Cabinet approved the CHBC model policy document tabled in parliament. There is no one specific model of CHBC. National government has given provincial health and social development departments a guide which includes five models for CHBC (see Appendix B) (Departments of Health and Social Development, 2001). Provincial departments and community service providers are to use it when developing their business plans, designing the structures and implementing them.

1.3.1 Definition and purpose of CHBC

The DSD defines CHBC as:

> *Home care is defined as the provision of comprehensive services, including health and social services, by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health, including care towards a dignified death.*
>
> *Community based care and support is the care/services that the consumer can access nearest to home, which encourages participation by people in the community. This approach encourages traditional community life and creates responsibility within the community.*
>
> *(Department of Social Development Presentation to the Portfolio Committee, 2001)*

The objectives of the CHBC programme are therefore:

- To shift the emphasis of care to the beneficiaries - the community
- To ensure access to care and follow-up through a functional referral system
- To integrate a comprehensive care plan into the informal, non-formal and formal health system
- To empower the family/community to take care of their own health
- To reduce unnecessary visits and admissions to health facilities
- To ensure that children and families who are affected by HIV/AIDS access social welfare services within their communities

The beneficiaries of the service are:

- Asymptotic HIV positive persons
- People recovering from illness and who might be in need of specific treatment and assistance after being discharged from hospital
- Terminally ill persons
- Persons living with HIV/AIDS or any other debilitating disease and/or conditions
- All categories of caregivers
- Families
- Children infected and affected by HIV/AIDS
- The entire community

1.3.2 Interdepartmental coordination of CHBC

The CHBC programme aims to combine the care of persons with AIDS (adult sufferers) with the care of those affected by the disease (children, dependants etc.). Health provides for the health needs of the infected person, and DSD buys school uniforms and pays school fees, establishing childcare committees etc (see Appendix C for a detailed description). Table 1 illustrates the sector responsibilities:

Table 1: Sector Responsibilities of Health and Social Development

HEALTH	SOCIAL DEVELOPMENT
Provide basic home care supplies and conduct home visits. Assess care needs (nutrition, physical care, and emotional support). Train and support care givers. Counsel clients and caregivers. Develop care plans and provide care.	Facilitate community mobilisation. Establish childcare committees. Train volunteers. Identify vulnerable children and families (home visits). Identify community needs and resources.
Provide information, education and communication materials.	Provide material assistance (food, clothing, shelter).
Provide Directly Observed Treatment Supervision (DOTS) for TB.	Identify and provide: Alternative care for orphans Residential care Foster care Adoption
Liase with health services.	Counselling and support
Provide referrals to health providers.	Monitoring and supervision of adoptions
	Social security Identification of eligible persons and assistance with accessing benefits
	Networking and referrals
	Poverty alleviation
	Capacity building Training family members, professionals and volunteers
	Monitoring

Source: Departments of Health and Social Development, 2001

Comment: Footnote what DOTS is.

1.3.3 Structures involved in implementing CHBC

According to the Constitution (1996), welfare services are the joint responsibility of national and provincial governments. The National Department is responsible for the development, implementation and monitoring of norms and standards, while the provincial departments are responsible for the planning, development and delivery of services. The different structures involved in the design and implementation of the NIP are as follows:

National level

Chief Directorate: Development Implementation Support
This programme aims to develop, implement and monitor strategies for poverty eradication, combat HIV/AIDS, and undertake community development and public-private partnerships.

Chief Directorate: Social Security
The programme develops, coordinates and facilitates the implementation, monitoring and evaluation of policies and programmes for social insurance and social assistance

Chief Directorate: Welfare Services Transformation
This programme aims to facilitate the transformation of welfare services to deliver effective and appropriate developmental social welfare services.

Chief Directorate: Population Policy
The Population and Development programme aims to facilitate changes to the determinants of South Africa's population trends, so that these trends support sustainable development in the country and southern Africa.

Provincial level

Chief Directorate: Welfare Services Transformation
The aim of the Directorate is to provide developmental welfare services in partnership with non-profit organisations and community based organisations.

HIV / Aids Component
Table 2 describes the functions for which the different HIV/AIDS coordinators are responsible. According to the description, the National HIV/AIDS Coordinator is responsible for the design of policies, while the provincial coordinators are responsible for the planning, implementation, monitoring and funding of the services.

Table 2: Functions of national and provincial HIV/AIDS structures in DSD

National coordinator for CHBCS in DSD: ***Coordinating functions***	**Provincial coordinators in DSD:** ***Coordinating functions***
Funding functions Technical expertise Liaison Policy and legislation development Strategic planning Standard generation	Funding Technical expertise Implementing policy, legislation and strategic planning Monitoring and evaluation Liaison

Source: HIV/AIDS Directorate, 2001.

2. Funding Mechanisms for CHBC

Comment: This title might help make the link with the previous section.

Provincial governments obtain their revenue (income) from three sources: conditional grants, provincial own revenue (i.e. provincial taxes and license fees) and the equitable share allocation (block grant). Conditional grants are earmarked funds given by a national department to a provincial department for a specific function (NDI, 2000). The funds for provincial departments to implement CHBC programmes are provided through conditional grants from the DOH and DSD. The rationale for using conditional grants to fund CHBCS instead of a block grant allocation is:

- *To ensure more accountability on the part of national and provincial offices regarding the utilisation of the allocated funds*
- *To enable provinces to access special funds for HIV/AIDS since most did not budget adequately for it. (DSD, 2001 c: Mobilising HIV/AIDS Financial Resources)*

Cabinet voted an amount of R450 million to be made available for the implementation of the NIP as a whole over a period of three years. An amount of R13 million was allocated to CHBC, in the financial year 2000/2001, R28 million for 2001/2002 and R68 million in the financial year 2002/2003 (DSD,2001).

2.1 Allocations to national DSD and provinces

In 2000/01, R 6.8 million was allocated to the DSD for the implementation of CHBC. Of this amount, R 5.26 million was allocated to six provinces (see Table 3) to pilot the implementation of the CHBC programmes. That year, the national DSD retained the rest of the funds (R 1.180 million) and distributed them to existing projects in order to strengthen them. Of the R1.18 million, R 57, 700 was spent on administration and travelling costs.

Table 3 gives a breakdown of the allocations. In the 2001/2002 financial year provincial DSD will receive a combined amount of R12.5 million and national an amount of R900 0000.

Table 3: HIV/AIDS share of conditional grant allocated to provincial DSD

Province	2000/2001	2001/2002
Eastern Cape	950 000	1 500 000
Free State	910 000	1 500 000
Gauteng		1 000 000
Kwazulu-Natal		1 500 000
Mpumalanga	960 000	1 500 000
Northern Cape	1 000 000	1 500 000
Northern Province	800 000	1 500 000
North West	1 000 000	1 500 000
Western Cape		1 000 000
Amount distributed to provinces	5 620 000	12 500 000
Amount retained by National DSD	1 180 000	900 000
Total for CHBCS	**6 800 000**	**25 900 000**

Source: National Treasury, 2001.

Table 4: National share of HIV/AIDS grant allocated to existing projects, 2000/2001

Province	Place	Allocation
Eastern Cape	Kids Beach Development	138 250
Gauteng	Mission Society Care	200 000
Kwazulu-Natal	CINDI	30 000
Kwazulu-Natal	Koningsdal HIV/AIDS Centre	200 000
Western Cape	Khululeka Women's Group	100 000
Western Cape	Tembalabantwana	304 000
National	Administration & Travelling	57 750
	Total	**1 180 000**

Source: Ibid.

Comment: If this is entitled 'National Share' I would include the percentages, perhaps by project and by province.

2.2 What informed the departmental allocation of the NIP funds?

The focus of the HIV/AIDS strategy is on prevention. This objective is reflected in departmental allocations. In 2000/01, the DSD received 11% and in 2001/2002 10% of the total NIP funds, compared to Education and Health. (See also the Introductory paper on the NIP).

2.3 What informed the provincial distribution of the grants?

The aim of the HIV/AIDS grant is to pilot appropriate home and community care based models; replicate existing models of care and to implement community outreach programmes (National Treasury, 2001). In 2000/01 the piloting of the programme was restricted to one site per province in the six identified provinces. In 2001/2002 the CHBC is to be extended by three additional sites in the six provinces. Therefore each province received R 1 500 000 to develop appropriate models of home-based and community care models, except for the Western Cape and Gauteng who received R 1 000 000 each in 2001.

Thus in 2000 and 2001 costing was not used in the determination of the provincial distribution of grants. Appendix D gives a more detailed analysis of the work done on costing home-based cared given varying scenarios.

In 2000 the allocations to provincial DSDs were based on a 1999 audit on the readiness of the health and NGO sectors to deliver home-based and community support programmes. Gauteng, Kwazulu-Natal, and Western Cape did not receive funding in 2000 on the basis that they already had established CHBC programmes.

2.4 How were the funds disbursed to NGOs?

Funds are distributed to district offices and NGO's after they have submitted their "costed" business plans to the provincial office. Funds are distributed to the NGO/CBO service providers through the following procedures:

- The provincial DSD invites business plans from the non-governmental sector for the provision of HIV/AIDS related services (for specific target groups as well as geographic areas or communities). The business plan must specify the expected outcomes of the services to be rendered in terms of the numbers, duration and type of service.

- The HIV/AIDS unit appraises/evaluates and approves the business plans as they are or with some minor adjustments. Where adjustments have been made, these are then negotiated with the prospective service provider before final approval.

- Funds are then transferred to the respective service providers upon completion of a number of administrative processes, which include: contractual agreements; approval by Departmental Management; clarification of financial and administrative capacities of service providers.

3. Problems encountered with implementation of NIP in 2000

General Problems

At a national level the DSD is still in the process of establishing an HIV/AIDS directorate and recruiting staff to the programme. The national departments of Health and Social Development identified the following challenges during the first year of implementation of CHBC support programme:

- Lack of understanding of the integration of the components and of development of an integrated plan. The respective heads of departments did not sign off on plans which were received. This resulted in severe retardation of the implementation process.

- Lack of understanding of the link between the NIP and the different option models.

- Lack of institutional arrangements for implementation of the programmes.

- Acceptable business plans were received late from provinces thus leading to late transferral of funds and under expenditure. None of the funds from Health for CHBCS were released in 2000 (DSD, 2001 Mobilising Funds to fight HIV/AIDS) The money was not allocated due to the following reasons:

    - ⇒ Lack of human and resource capacity within provinces
    - ⇒ Lack of understanding of accessing funds from national
    - ⇒ Late submissions of business plans
    - ⇒ Lack of knowledge of legislation such as the Public Finance Management Act
    - ⇒ and process in accessing the funds.

- Apathy at community level and lack of understanding of the process. Communities feel that they are entitled to services without necessarily participating in the process of implementing these services.

- Staff turnover within provinces led to lack of continuity.

- Lack of funding for the model option.

Provincial problems

Disclosure of HIV/AIDS status. All provinces identified the unwillingness of infected and affected people to disclose their HIV/AIDS status for fear of stigmatisation and isolation. This

affected the targeting of service delivery to targeted beneficiaries. Many vulnerable people were left without any support due to fear of reprisal from their communities.

Distribution of funds. The funds were distributed in three tranches (1 November, 23 November and 21 January 2001) from the National DSD to provincial departments. Provincial officials felt that the main criteria for the short space between transfers were to spend the money before the end of the financial year, rather than spending time to ensure proper targeting of programmes.

Different procedures for accessing funds. The Departments of Health and Social Development required different procedures for accessing funds, even though they are both expected to deliver CHBC support programmes.

Referral of infected individuals. People who are discharged from hospital are often not supported by CHBC because of the lack of a proper referral system between the different institutions and departments.

Late hiring of coordinators. Coordinators were only appointed after the start of the current financial year 2001. A lot of their time was thus taken up by workshops trying to develop appropriate strategies to implement the programme and getting accustomed to their new responsibilities. In many instances they have other functions in addition to their CHBC coordinating responsibilities.

Part II: The Role of the PRP in fighting HIV/AIDS

The link between poverty and HIV/AIDS is important for designing policies to mitigate the impact of the disease. One of the key strategies is to support and strengthen existing and new CHBC programmes through engaging affected and effected people in economic development activities to secure self-reliance. The DSD also links the reduction in poverty with the ability of communities to adhere to NIP educational and awareness programmes aimed at controlling the spread of the disease.

In other words, CHBC and Life Skills programmes are more effective if poverty is addressed concurrently. The PRP is an important source of income for those infected and affected since the current social security system has many gaps pertaining to people infected and affected by HIV/AIDS (see Part III).

1. Policy Objectives

The PRP was initiated in 1997/1998 and aims to create sustainable income-generating projects in poor communities and at the same time augment the income of people receiving non-contributory state pensions. 2001 marks the first time that the National DSD has incorporated HIV/AIDS as part of the PRP objectives and implementation plans.

In the formulation of the main objectives, the DSD considered various aspects that impact on poverty in South Africa. Food security, food shortage and low income levels, unemployment and underemployment, social crime and HIV/AIDS, the limitations of existing social assistance and the reduced asset base and no access to credit in communities, have all been prioritised as key objectives for the next three years. HIV/AIDS also ranks considerably high amongst these priority areas, as it is features a number of times in these objectives.

1.1 Expected outputs and impact

For each objective, the department has identified specific outputs and expected impacts, as set out below:

Table 5. Expected outputs of PRP

Objective	Expected Output
Food Security	144 food production clusters [2]
Social support structures	100 HIV/AIDS community-based support structures in partnership with local role players
Urban regeneration strategy	18 pilot skills development centres[3]
Income generating opportunities for rural women	100 income generating initiatives for rural women together with 10 000 employment opportunities
Community-based child care initiatives	100 dual purpose centres for the aged, together with 500 production opportunities and child care facilities for 2500 children
Economic & employment opportunities	At least 2% of all projects will capitalise on the capacities of the disabled
Social finance capacity	At least 60% of projects will be linked to the Social Finance programme

Source: Department of Social Development, Poverty Relief Programme: Business Plan 2001/02.

The expected impacts of the PRP are:

- 472 viable local and institutional structures (partnerships) for the sustainable management and maintenance of poverty relief projects throughout the country within a 3 year period;
- An improvement in social support structures to poor communities affected by HIV/AIDS;
- Decrease in the number of malnourished children through improved food security;
- Decrease in reputed child neglect and abuse as a result of impoverished household stability;
- The prevention of social crime as a result of alternative prospects of young people;
- Improved economic prospects for rural women;
- Increased social economic support for the aged;
- Integrated approach to development in the support of the aged and children;
- An increase in the number of disabled people who are involved in productive activities within all target areas;
- An increased level of savings and access to credit for impoverished communities;
- An improvement in the sustainability potential of the PRP projects.

1.2. Allocations per objective

Table 6 shows that in the current financial year R50.4 million has been budgeted for PRP, R 106.6 million in 2002/2003, and R71 million in 2003/2004. The table also shows that food

[2] Each cluster will comprise of 100 households which total 14 400 households in food production. Of this 15.4 % will be households affected by HIV/AIDS.
[3] 2 pilot projects in each province for 500 young individuals per pilot project. This will take place in identified urban areas with high social crime situations.

security, income generating activities and community based-child care initiatives are prioritised within poverty relief. Each were allocated R10 million or more compared to the R1.5 million for projects focusing on people with disabilities in the 2001/2002 financial year.

Table 6: Expenditure break-down per main project

Projects	2001/2002	2002/2003	2003/2004
Food security	R10.88 million	R29.6 million	R20 million
Social support structures	R5 million	R12.5 million	R7.5 million
Skills & employment opportunities	R9 million	R9 million	R9 million
Income generation activities	R10 million	R25 million	R15 million
Community-based child care initiatives	R10 million	R25 million	R15 million
Initiatives to integrate the disabled	R1.5 million	R1.5 million	R1.5 million
Social Finance capacity	R4.02 million	R4 million	R3 million
Total	R50.4 million	R106.6 million	R71 million

Source: Ibid.

1.3 Provincial distribution

Table 7 provides a provincial breakdown of the number of projects for July 2001. It shows that in the 2000/2001 financial year more than 663 projects were operating nationally. Kwazulu-Natal (203) had the most projects and the Western Cape (8) had the least number of projects. However the number of projects decreased by 66% between 1998 and 2001 mostly due to capacity (human resources) problems at national, provincial and community level. We also see a decrease in allocated amounts of more than R470 million in nominal terms for the same period.

Table 7: Provincial project breakdown

Province	No. projects 1998/1999	Amount allocated	No. projects 2000/2001	Amount allocated
Eastern Cape	652	16 307 781	23	14 838 900
Free State	142	7 864 804	50	7 823 857
Gauteng	109	8 990 067	77	11 842 340
KwaZulu-Natal	389	21 463 657	203	17 273 120
Mpumalanga	135	9 385 871	56	8 077 275
North West	117	8 300 210	110	6 173 000
Northern Cape	121	10 432 550	18	4 841 000
Northern Province	165	16 073 465	78	11 953 499
Western Cape	106	11 581 500	8	7 899 060
National	39	67 201 067	40	39 830 941
Total	1 975	177 600 964	663	130 552 992

Source: DSD, 2001. Briefing by the Department of Poverty Projects of the Portfolio Committee for Social Development, 23 August 2001.

1.4 Target groups

The PRP targets the poorest 20% of the population. The Department's anti-poverty strategy will target the following key groups:

- Rural women;
- Households affected by HIV/AIDS;
- Malnourished and neglected children;
- Out of work youth;
- The aged;
- People with disabilities; and,
- Targeted poverty pockets in each province.

2. HIV/AIDS Component of the Poverty Relief Programme 2001/2002 –2003/2004

The national DSD's poverty relief programme is currently in its second three year funding cycle. Community income generating projects are funded for a maximum of three years after which they are expected to be self-supporting.

The DSD aims to establish 100 community–based social support structures in communities with the highest HIV/AIDS prevalence rates and link them to the CHBC support structures. Implementation will proceed in three stages:

- Year One, 2001/2002, focuses on establishing community-based institutional structures and identifying specific projects.

- Year Two, 2002/2003, will focus on job creation initiatives and social support facilities.

- Year Three, 2003/2004, will seek to reduce support on the basis of increased self-reliance of the job creation initiatives and the strength of collective resources from local partnerships (DSD,2001).

2.1 Allocations for HIV/AIDS projects of PRP

A total budget of R 25 million has been budgeted for HIV/AIDS over the next three years (2001/2002 –2003/2004). In the current financial year, R5 million of the R 50.4 million has been allocated to HIV/AIDS targeted poverty programmes. In 2002/2003, R 12.5 million, and in 2003/2004, R 7.5 million. HIV/AIDS specific budgeted allocations constitute on average 10% of the total provincial PRP allocation.

Table 8 provides a breakdown of the allocation to the HIV/AIDS component of the PRP. The table shows a percentage increase in the HIV/AIDS share of poverty allocations from 2000/2001 and 2002/2003, and a slight decrease of 0.8% between 2002/2003 and 2003/2004.

Table 8: Total allocation (R million) 2000/2001-2003/2004

	2000/2001	2001/2002	2002/2003	2003/2004
PRP Allocations (Nominal)	R120 million	R50.4 million	R106.6 million	R71 million
HIV/AIDS Allocations(Nominal)	R 8.5 million	R5 million	R12.5 million	R7.8 million
% HIV/AIDS	7%	9.9%	11.7%	10.9%

Source: Ibid.

Table 9 provides a provincial distribution of the HIV/AIDS PRP funds. It shows great variation among provinces in the share of PRP funds which are dedicated to HIV/AIDS-specific projects. The Eastern Cape allocated 7% to HIV/AIDS compared to the 20% of Free State , Gauteng and Mpumalanga.

Table 9: HIV/AIDS allocations from PRP, by province

Province	2001/2002	2002/2003	2003/2003
Eastern Cape			
HIV/AIDS allocation	500,000	1,250,000	750,000
As percent of provincial PRP funds	7%	7%	6%
Free State			
HIV/AIDS allocation	1,000,000	2,500,000	1,500,000
As percent of provincial PRP funds	20%	22%	21%
Gauteng			
HIV/AIDS allocation	500,000	1,250,000	750,000
As percent of provincial PRP funds	20%	26%	22%
Kwazulu-Natal			
HIV/AIDS allocation	1,000,000	2,500,000	1,500,000
As percent of provincial PRP funds	12%	13%	12%
Mpumalanga			
HIV/AIDS allocation	1,000,000	2,500,000	1,500,000
As percent of provincial PRP funds	20%	22%	20%
Northern Cape			
HIV/AIDS allocation	150,000	375,000	225,000
As percent of provincial PRP funds	6%	7%	6%
Northern Province			
HIV/AIDS	200,000	500,000	300,000
As percent of provincial PRP funds	3%	3%	3%
North West			
HIV/AIDS	500,000	1,250,000	750,000
As percent of provincial PRP funds	11%	13%	11%
Western Cape			
HIV/AIDS allocations	150,000	375,000	225,000
As percent of provincial PRP funds	7%	9%	8%

Source: Department of Social Development, Poverty Relief programme: Business Plan 2001/2003.

2.2 What informed the provincial distribution of the HIV/AIDS component of the grant?

The head of the national PRP programme decides how much is going to each province on the basis of HIV/AIDS *prevalence* and *poverty statistics*. Because of the right to privacy guaranteed within the Constitution and the stigma attached to HIV/AIDS, the PRP will not be able to directly target HIV/AIDS sufferers. The programme will rather concentrate on affected individual and magisterial or geographical locations with high infection rates.

2.3 Process for distributing funds

Project funding from the province is accessed by submitting business plans/proposals. The National Department pays conditional grants directly into the provincial accounts. Project or programme related funding are is disbursed through the Independent Development Trust (IDT) and are paid in three annual tranches i.e. 50%, 40%, 10%, or in two tranches of 60% and 40%, Funds are disbursed electronically to minimise corruption.

Nationally all PRP funding is disbursed through IDT to organisations applying for funding. IDT acts as a disbursement conduit, used by the national office to channel funds to beneficiary projects. The Director General of the National Department of Social Development is the Accounting officer for the PRP. She approves projects and instructs the IDT to disburse funds.

In the case of provinces, the Heads of Provincial DSD are responsible for the authorisation and disbursement of funds. Projects have access to these funds through the submission of business plans, which provinces receive directly from projects or via district offices. The funding proposals are assessed by all welfare components (i.e. disabled, restorative justice, HIV/AIDS, NGO) who then make recommendations to national for funding for these projects. National forwards applications to the Director General (DG) for approval, after which IDT is authorised to process payments.

This process also includes the completion of a readiness (e.g. bank account) form that is sent to the national department. The agreement, which the provinces enter into with a project, stipulates that projects must submit progress reports and financial statements to the Department on a monthly basis. In cases where a grant exceeds R200 000,00, an audited report by a registered auditing firm must be submitted to the Department within 2 months of the end of the financial year.

The steps below outline the process:

Step 1: Vote allocated by National Treasury to DSD.

Step 2: According to predetermined cash flow plan, and approval by National Treasury, DSD releases first tranche to IDT.

Step 3: Provinces access and prepare projects for accessing funding according to Provincial Division of Revenue figures. These are approved by MINMEC and Treasury (DSD, 2001: Presentation to Portfolio Committee 23/08/2001).

Step 4: Provinces recommend their projects for funding to the DG.

Step 5; DG approves. Provinces enter into agreements with the projects.

Step 6: DG and National Programme Manager instruct IDT to release funds to project.

Step 7: IDT captures project into their system and gives project a number.

Step 8: IDT sends verification form to the province for the HOD to verify and confirm:

a) existing project, (b) correctness of the project details, and (c) correctness of bank account details.

Step 9: Verification form returned to the IDT.

Step 10: IDT captures verification form and process payment electronically, which takes a maximum of five working days upon receipt of the verification form.

3. Challenges encountered during the implementation phase

3.1 National

Child-headed households. According to the Department, the child-headed household is a new phenomena which the Department is still in the process of incorporating into its project designs. Until now the project targeted adults. It is also illegal for children younger than 16 years of age to be employed in South Africa.

Lack of capacity at project level. The main obstacles experienced in the implementation of HIV/AIDS programme and funding are: human resources; late payment of funds; capacity building to service providers; non-existence of policy; and lack of transport. The projects are located in the poorest parts of the country, and many have poor book-keeping practices.

Financial institutions. The Department uses banks to distribute funds to projects. When a bank account fails to show activity for more than a couple of months, they are closed. This has resulted in funds being returned to the IDT, delaying the progress or implementation of projects. The lack of adequate staff and the timeous payments of funds were identified as major obstacles.

Annual Financial Year. The process of accounting for funds and progress within a given financial year is not conducive to the process of building participatory processes important to the developmental paradigm shift adopted by the Department. Because of the pressure to spend and account for funds within a given year, the overriding priority becomes the spending of funds rather than developing the necessary participatory or inclusive approach.

3.2 Provinces

Additional problems the provinces encounter include:

Disclosure of HIV/AIDS status. One of the biggest problems in targeting persons with HIV/AIDS was the unwillingness of infected people to disclose their HIV/AIDS status.

Referral of infected people to projects. Provinces lack the availability of established resources/structures to secure proper referral of persons with HIV/AIDS to be engaged in projects.

Introduction of AIDS component. A number of provinces mentioned that this is the first year that the PRP introduced and interfaced HIV/AIDS as part of its objectives. Since provinces are only now in the process of drawing-up their business plans for the next three-year funding cycle, they have not yet done any evaluations with regards to HIV/AIDS and the PRP.

Integration between different programmes. Collaborative planning and co-operation between all role players were absent for the development and implementation of effective strategies.

Part III: Linking Social Security with Poverty Relief and CHBC

Whilst there is fluidity around the exact content of the CHBC from community to community and province to province, there is a common understanding between government representatives and potential community participants that social security payments must form a part of the model for it to be effective.[4] This argument is a natural outflow of government's realisation that HIV/AIDS impacts are concentrated in poor households and provision of income is necessary for relief and prevention.

Thus income support – via social security payments and job creation / sustainable income generation projects – is part of government's HIV/AIDS prevention and mitigation strategy and is reflected in planning documents and workshop discussions.[5] For example, household income is stretched too far when parents become sick or die, and children with no parents need to access grants or find ways to continue receiving a grant.[6] Furthermore, social security payments comprise on average 90% provincial welfare budgets (Adams, 2001, p.1).

South Africa's income support for the poor is largely limited to its state administered social grants. The significance of social security as a means of poverty relief in South Africa, together with the link between HIV/AIDS and poverty:

- Makes it likely that by throwing people into or deeper into poverty HIV/AIDS impacts will lead to an increase in grant eligibility and - in the absence of substantial decreases in population size - an increase in demand for social grants via the means test.

- Implies that if government wants to prevent HIV/AIDS, income support -, through social security payments and other means - is a crucial instrument.

- Implies that income support will be a core need that must be met if government is to offer relief to households suffering HIV/AIDS impacts.

[4] See for example the annexure to government's `Integrated Home/Community Based Care Model Options', p 4, where it says that a role of the social worker in the model under discussion is to `refer the patient for application of a grant or other financial support services and community mobilisation'.
[5] For evidence of government's realisation that income support – partly through social security payments – must form part of the mitigation efforts, see the following government documents: Departments of Social Development and Health, 2001 `Integrated Home/Community Based Care Model Options'; and National Departments of Health, Education and Social Development, 2000 `National Integrated Plan for Children Infected and Affected by HIV/AIDS'.
[6] Workshop held in June 2001 to help Provinces fast-track CHBCS.

1. Overview of Social Security in South Africa

A social security grant refers to a cash transfer, usually in the form of a monthly payment, to a citizen by government. It is called a transfer because money is paid without the beneficiary having to offer services in return.

1.1 The five main grants within the South African system

The social security system in South Africa is built around five main grants.[7] Welfare services (of which payment of social grants is one part) is a concurrent competence of provincial and national government (Schedule 4, South African Constitution). In practice this means that national government takes the lead in policy and legislation, and provincial government is responsible for implementation. It is therefore provincial governments that actually pay beneficiaries their social security grants. Many provinces have sub-contracted private consultants to assist them with this.

Grant type	Share of monthly expenditure on provincial social security, June 2001
Old age pension	68%
Disability grant	20%
Child support grant	10%
Foster grant	1%
Care dependency grant	1%

Appendix D gives a chart listing the value and eligibility requirements of each grant.

1.2 Which grants are infected and affected people entitled to?

People infected and affected by HIV/AIDS are entitled to the following grants:

- Children and adults so sick from HIV/AIDS that they are looked after full time at home are eligible for the care dependency grant (again a medical certificate is required).
- Children that pass the means test in terms of income can access the child support grant through their care giver.
- Children that have been placed in the care of foster parents through the courts can access the foster care grant.

2. DSD research finding on HIV/AIDS impact on Social Security Budgets

In June 2000, a paper titled `*Impact of HIV/AIDS on State-Administered Social Security Grants*' was presented at the Welfare, Population and Development MINMEC. Its aim was to provide `estimates of impact of HIV/AIDS on major social assistance programs of the Department of Welfare up until year 2010 based on epidemic projection models, data on eligibility, uptake and cost of individual grants, and population data on the numbers of

[7] According to national government's SOCPEN data base which records the number of and expenditure on payments for each grant in each province every month.

candidates who would potentially receive grants' (National Department of Social Development 2000:1).

The paper considered potential increases in the demand for four of the five main grants – it left out analysis of the impact of HIV/AIDS on the old age pension. Assumptions which underpin the model used to make projections include:

- That HIV/AIDS will slow population growth dramatically, and lead to a negative growth in some areas, particularly amongst children.[8]
- That the number of orphans will increase substantially, and that between 5-10% will be looked after in institutional care (state financed), and 30% will be adopted. The take-up rate of the foster grant for the remaining children will be 14% (current rate).
- That the take-up rate of the child support grant will continue to grow rapidly and that this effect – which serves to increase demand - will outweigh the decreased number of children which is due to increases in child mortality and decreased birth rates.
- That there is no effective government programme to reduce mother to child transmission of HIV.

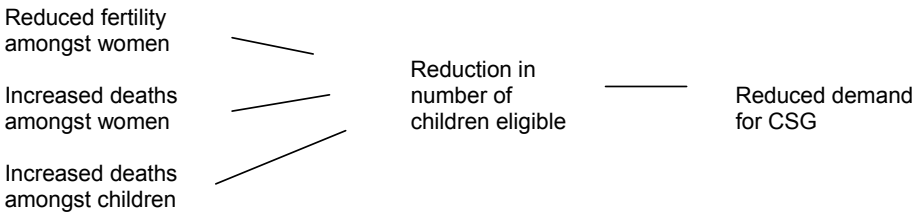
Government planning for the impact on the grants

The paper finds that HIV/AIDS *will* increase the demand for grants, but the *size of the effect is moderate*. The primary way in which HIV/AIDS will increase the demand for grants in this model is through the foster care grant. Increased demand for all grants up until 2010 is in this model driven by increased demand for the child support grant. But, the increased demand for the child support grant is a function of the increased take up rate effect outlined below, and hence is unrelated to HIV/AIDS impacts. The paper projects a growth rate in expenditure on the child support grant for the period 1997 to 2001 of about 160% and that it will then rise to about 700% by 2010.

Comment: I might be getting confused but the time periods for the growth rates don't appear identical, and therefore comparable, between the fcg and ccg.

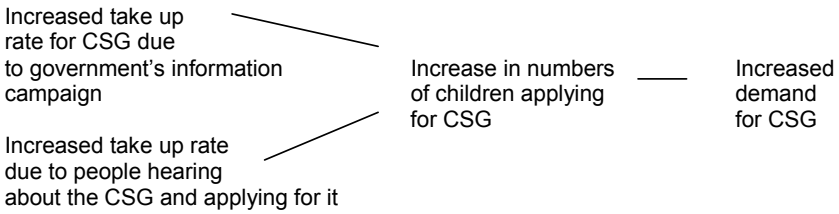
Two opposing effects influencing the demand for the child support grant

Effect 1 – The demographic effect, which *is* related to HIV/AIDS



Effect 2 – The take up rate effect, which *is not* related to HIV/AIDS

[8] The significance of the assumption about population shrinkage can be seen starkly in the discussion around the impact of HIV/AIDS on the child support grant eligibility figures. The paper states that: `Excluding children who are orphaned, numbers of eligible are expected to decrease from approximately 3.3 million eligible children in the year 2000, to approximately 2.8 million by the year 2010. Decrease in numbers of children overall are a function of smaller numbers of women of child bearing age due to HIV/AIDS, lower fertility amongst HIV positive women, and deaths amongst infected children. (National Department of Social Development, 2000, p.6).



For the foster grant the model projects a growth rate in expenditure relative to 1995 of about 400% by 2010. The growth rate in 2001 relative to 1995 is about 60%.

Regarding the two disability grants, the model projects `AIDS will *not* have a substantial effect on the number of eligible or actually receiving disability grants, including the care dependency grant (while making the reservation that this might change if anti-retroviral drugs become widely available.) This is mainly due to the low number of people disabled by AIDS at any one time, and relative short period of disablement before death' (Ibid). The demand for disability grants does increase in these projections, but moderately – around 60% between 1995 and 2010 – and the effect of HIV/AIDS in changing demand is thus small.

Care dependency grant expenditure is projected to increase by around 30% between 1995 and 2010. In 2001 the growth rate is less than 10% relative to 1995. (Ibid, Figure 8, p.11).

The conservative projections of the demand for social security payments in this paper are at odds with other government documents that suggest that `HIV/AIDS will have a profound influence on social assistance in South Africa'. (National Department of Health and Social Development, 2001:1). They are also at odds with the suggestions of work by Haarmann (2001) which has modelled the impact of HIV/AIDS on the social security budget through its impact on the disability grant. The different projections about the impact of HIV/AIDS on social security budgets can be traced largely to different assumptions about eligibility for the grants – particularly the disability and foster grants – and different assumptions about how HIV/AIDS will affect income poverty.

3. Actual trends in provincial social security payments and provincial social security budgets

We have not managed to gain access to data on the number of beneficiaries of the five main grants. Hence, we use the data on the *number of payments* of the five main grants to track changes in demand for the grants over time. This is done in section 3.1.

To cast light on whether provinces are budgeting for large increases in demand for grants due to HIV/AIDS impacts, in section 3.2 we present the data on *budgeted expenditure* on the five main grants for the provinces for 2000/01-2003/04. We were however unable to collect this data from all nine provincial social security departments.

3.1 Trends in the number of payments of the main grants

Table 11 shows that the number of child support grant payments grew by 95.26% between June 1999 and June 2001. The DSD aims to have 3 million child support grant beneficiaries

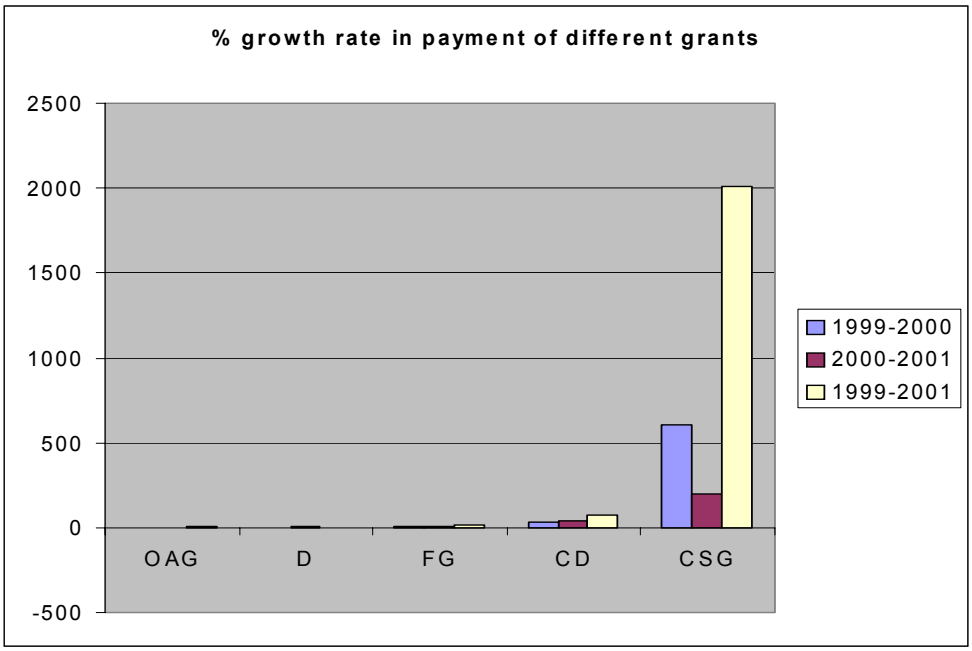
by 2003. The care dependency grant showed the second fastest growth rate at 43.7%, followed by the foster care grant(15.5%), old age grant (3.9%) and the disability grant(1.3%)

Table 11: Payments of the main grants June 1999, June 2000 and June 2001 (all provinces)

Grant type	June 1999	June 2000	June 2001	% Growth June 1999-June 2001
Old age	1 830 073	1 876 848	1 905 820	3.9
Disability	634 521	601 950	643 225	1.3
Foster	46 256	50 228	54 754	15.5
Care dependency	18 156	23 215	32 267	43.7
Child Support Grant	40 921	289 731	864 710	95.2

Source: SOCPEN database, information supplied by National Social Development Department, June 2001.

Figure 1: The pattern in the demand for social grants, June 1999-June 2001



What does the data in Table 11 and Figure 1 suggest about what is happening to demand for grants?

Demand for all grants – most notably the child support grant - seems to be increasing. This means that it appears as if the effect of HIV/AIDS on population growth through death and reductions in the fertility of HIV positive women is not strong enough (yet?) to reduce the demand for grants. In fact, to the contrary, it seems as if demand for grants, most notably the child-specific grants, has been growing strongly over the last three years.

It is crucial to point out here that, although the DSD model of expected future trends in the demand for social security grants implies that increased demand for child support grants is unaffected by HIV/AIDS impacts, it is unlikely that this is the case. In fact, it is highly probable that the increased demand for grants – including the child support grant – *is* related to HIV/AIDS and this is *because of the close link between income poverty and HIV/AIDS*. HIV/AIDS is hitting poor communities hardest and is throwing more people *into* and *deeper into* poverty. This means that growing numbers of people are becoming eligible for and applying for the means tested grants (all except the foster grant) due to their precarious income situation.

The reason why the DSD model outlined above excluded the impact of HIV/AIDS on the expected change in the demand for the child support grant was because its assumption that HIV/AIDS would not affect the proportion of South Africa's population living in income poverty.

The rapid increase in the demand for the care dependency grant, whilst probably being influenced by HIV/AIDS infection amongst children, is also an outflow of government's new welfare policy, which includes closure of many residential child care facilities in favour of community based care. Many of the children qualify for the care dependency grant once they are placed with their families or adoptive parents (Adams, 2001).

3.2 The provincial actual expenditure for 2000/01 and estimates of expenditure for 2001/02-2003/04 on the five main grants

Appendix E gives data tables showing how much provinces are actually spending and planning to spend on these five main grants, as well as present growth rates in the budget allocations. Analysing the growth rates of expenditure can help us see if provinces are taking the impact of HIV/AIDS into account in budgeting for social security. The data gives evidence that:

- *There are wide variations across provinces in the growth rate of budget allocations to the different grants for the MTEF*. For example, in the budget for the foster care grant the growth rate in the budget allocation varies from only 1% for Western Cape for the period 2000/01 – 2003/04 to 245.9% for Northern Province for the same period. And, the growth rate in the budget for the care dependency grant for Northern Province between 2000/01 and 2003/04 is far more rapid than in the other provinces.

- *The child specific grants seem to be prioritised by provinces within social security budgeting for the MTEF*. This is shown by the provincial average of the growth rates of the budgets for the different grants over the period 2000/01 – 2003/04. The child support grant budget grows at a provincial average of 156.8%, the care dependency grant at a provincial average of 138%, the foster grant budget at a provincial average of 70%[9], the old age pension at 23.1% and disability grant at 21.4%.

- *With the exception of the rapid growth in the provincial budgets for the care dependency grant, the supply side trends in the relative growth rates of the grants appears in line with the DSD's predictions about the relative impact of HIV/AIDS on the different grants*. The child support grant allocations are growing most rapidly, followed by the foster grant

[9] This growth rate is very sensitive to the inclusion of Western Cape and Northern Province – two outliers in the budgeting for the foster grant over the MTEF. Excluding Western Cape, the provincial average is higher, at 83.8%. Excluding Northern Province, it is 34.8%.

budgets whilst the pension and disability grant budgets are growing more moderately.

- *It is difficult to see whether provincial budgeting does seem to have been influenced by HIV/AIDS impacts.* Relative to past years, the growth rates in provincial budgets for child specific social security payments of the provinces– with the exception of Western Cape in the case of the foster grant – seems to signal that provinces are planning to spend additional money for HIV/AIDS impacts through this channel.

  However, the impact of the reintegration of children into communities through fostering (as part of the deinstitutionalisation of care) on the demand for grants and increased take up rates attendant on the DSD's drive to increase awareness about the child support grant, could have a greater influence on these rapid growth rates than with HIV/AIDS impacts. The moderate increases in the budget allocations for pension and disability grant payments and fact that these are not rapid relative to previous years, signals that provinces are not currently budgeting a lot of money for mitigating HIV/AIDS impacts via this route.

4. Determining provincial social security allocations

The division of revenue occurs in three stages. It involves:

1. The deduction of an amount for payment of interest on state debt and the contingency reserve (known as the `top-slice').[10]
2. The division of total revenue between the three tiers of government (known as the `vertical split') the division of the total national funds available for the provinces revenue between the nine provinces (the horizontal split).

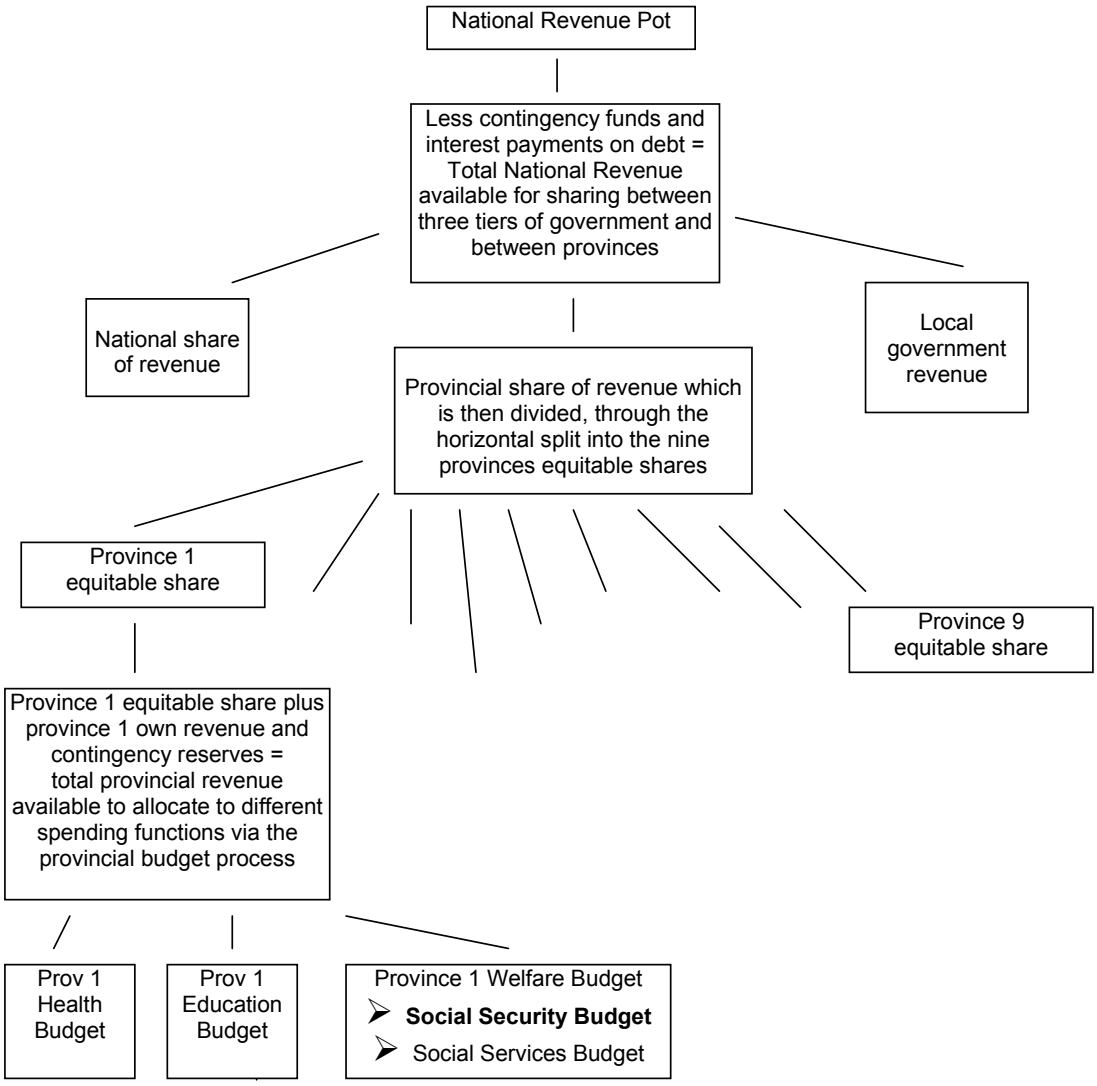
To decide on the horizontal split, a formula is used. The amount each province receives through this formula process (the horizontal split) is known as its `equitable share'. The welfare component of the equitable share is based primarily on the number of OAG, DCG and CSG beneficiaries in their provinces, as well as a number of other determinants.

Through the budget process, provinces decide how much of their total revenue to allocate to the different services they deliver (such as health, education and welfare / social development services). Budgeting for social security payments is made by provinces within their welfare / social development service budgets. We have not as yet managed to gather detailed information about exactly how provinces take their decisions about how much to allocate to the various social security payments when budgeting or how HIV/AIDS impacts are being factored into these decisions. What we do know in this regard was gathered from a specialist in social security budgeting in South Africa at the National Department of Treasury, John Kruger. It can be summarized as follows.

- Provinces take final responsibility for their own budget allocations for the current budget year in each MTEF and for their projections for the outer two years in each MTEF.

[10] Top-slicing is the practice of setting aside amount of money from the National Revenue Fund before the remaining funds are split up into the equitable shares of national, provincial and local governments (the vertical split).

Figure 2 – Where the social security budget fits into the budget



- In recent years, Treasury has developed a projection spreadsheet which has been shared with provinces and which is used by some of them for their projections. Annually, discussions between provinces and national government around how to budget for social security payments have taken place at the 4X4 and joint MinMEC meetings These discussions feed into the process of budgeting for social security payments in each province.

- The `treasury model' takes current SOCPEN numbers as the starting point, and projects likely cost on the basis of value increases and beneficiary growth rates.[11]

[11] SOCPEN is the social security payment database kept at the National DSD.

- In addition to being influenced by the National Treasury projections of beneficiary growth rates and value increases, provinces' budgeting for social security payments is influenced by the provincial resource framework and broad policy priorities.

5. Difficulties with grant access and eligibility

Confusion around which grants can be accessed, the design and implementation problems limiting coverage and Taylor Commission

Ideologically then, government seems committed to giving income support to poor households to prevent and mitigate HIV/AIDS impacts. Payment of income via social grants is one of the vehicles used. However there are difficulties with accessing and qualifying for the grants on both the supply and demand sides.

As regards adults, people with full-blown AIDS whose CDC count falls below 200 qualify for the disability grant. To access it, they have to be declared to be 'in need' by a medical doctor and then apply to the nearest social development office.[12]

On the demand side of the market, there are currently two problems for adults affected by HIV/AIDS. First, not all AIDS sick people are aware that they can claim the disability grant. Second, according to members of parliament involved in assessing AIDS patients through their medical work, there are instances when the application is turned down or it takes a long time for the application process to bear fruit.[13]

Factors affecting demand for grants

On the demand side of the market:

- There are information and other implementation problems that are limiting effective demand (such as the cost of transport to gain access in rural areas and the need for a birth certificate and ID document). This affects all three of the child specific grants.

- The following design flaws in the system are ensuring that the system does not cover sufficient children infected and affected by HIV/AIDS, of which the most vulnerable and growing group are orphans. These problems include:

    ⇒ The fact that children have to be placed in the care of foster parent by the courts to access the foster grant and that only six grants can be paid to any one foster parent(s).[14]

    ⇒ The need for the care-giver to access the child support grant for children. (Many children affected by HIV/AIDS living in child-headed households thus struggle to get the grant).

[12] Joint presentation on the CHBC initiative by representatives of the National Departments of Social Development and Health, June 2001.
[13] Representatives at the Parliamentary Committee Meeting held by the Health and Social Development Portfolios, March 2001.
[14] This is at odds with the encouragement of informal fostering in the community as part of the CHBCS programme.

⇒ The fact that the child support grant is only for children age 0-6. This leaves out many children (age 7-17) who may be desperately poor in the wake of a parent or parents' death,

Key Issues and Conclusion

Ensuring adequate provincial budgets for CHBCS

According to the Departments of Health and Social Development (2001), the HCBC support programme is likely the cheapest option for dealing with the impact of the disease and providing constitutionally mandated services. However, the implementation of HCBC requires substantial additional funding for provincial Health and DSD departments. The costing model presented to parliament in February 2001 showed that, to have 1 200 fully-fledged HCBC teams by 2010/2011, it would require a budget of R 1.129 billion and R 1.335 billion.[15]

As yet, it is not clear whether additional funds will be made available for the implementation of the HCBC programme. In the current financial year provinces have a combined budget of R2.5 million for HCBC programmes in conditional grants only (excepting Gauteng and the Western Cape which have R2 million each at their disposal). However the costing study projected that the combined cost of reaching the target of 200 HCBC programmes by March 2001/2002 would be R120-125 million. Clearly, provinces did not budget adequately to implement the HCBC programme, nor will the conditional grant allocation be sufficient at its present level.

Improving funding mechanisms at local level

As described, conditional grant funds for the CHBC programme flow to provinces via both the DOH and DSD. The lack of an adequate interdepartmental funding mechanism was highlighted as another problem (Departments of Health and DSD, 2001), although DSD's previous attempts to raise the issue with the National Treasury were unsuccessful. Provincial coordinators often mentioned the lack of a common budget for the two departments as a major stumbling block to implementation, as well as the different criteria for grant approval used by each department.

According to the Department, the central problem in the successful delivery of HBCB at a local level is "how to transfer funds to communities with minimum bureaucracy and maximum flexibility whilst ensuring proper accountability." Provincial coordinators and project managers highlighted the following critical factors for effective funding mechanism at the local level:

- Pool "health" and "social development" funds in a unified local budget.
- Contract with a legally constituted NGO / CBO (i.e. a "legal person), preferably without complex tendering requirements, where such organizations have a presence.
- Where more "formal" NGOs do not have a strong presence, to establish funding, management and accountability frameworks with local community-based organisations (e.g. residents' associations etc.) – i.e. establishing accountable partnerships without the legal paraphernalia of tenders etc.

[15] This estimate assumes the needs based approach, if the stipend is set at R500,00 per month per care worker. Using the needs-based approach, the estimate is higher: R1.335 billion.

- Where local community capacity or motivation is too weak to engage in partnership provision of CHBC, to be empowered to employ CCGs and provide CHBC directly through government structures.
- The accounting officer in the local government structure assumes responsibility for the funds according to the Public Finance Management Act.
- The onsite manager responsible to the accounting officer in the local government structure.

However, it is clear that many of these conditions were not present during the first year of implementation at provincial level. Even though conditional grants were introduced to ensure that earmarked funds are spend for intended purposes, the health allocations were not spent. The Department attributed this to the lack of capacity at provincial level—while provinces identified difficult process and late advertisement of the grant by National Health as the main obstacle.[16]

The PRP has been plagued by under-spending and rollovers since its inception in the 1997/98 financial year. The funding for the programme is also in the form of a conditional grant to provinces from the national DSD. The projected poverty relief allocation for 2001/02 was R203 in Budget 2000; this has been changed to R50m for 2001/02. This reflects a decrease of R153m for the current financial year 2001/02. The national DSD acknowledges that it has a capacity problem and this is the main reason for the decline in the poverty relief allocation over the medium term.

In summary, in both cases (HCBC and PRP) Conditional Grants were introduced as the preferred fund allocation method, however, both programmes were plagued by under-expenditure problems related to capacity (human resources) at national and provincial level.

The assigned role of DSD within the NIP strategy document is to provide support for those affected and infected by the disease and thereby indirectly support prevention through PRP and social grants (as discussed in parts II and III of this paper). It is against this background that the inability to spend earmarked funds should be measured. A programme is only as effective as the ability of a manager at district level is able to fund projects and programmes in the prescribed time.

Integrated Approach by DSD and DOH

The NIP acknowledges that a multi-dimensional approach is required for effective government intervention. The strategy documents require that different departments (education, health and welfare) align their programmes and strategic plans. However, the relationship between the two departments responsible for the delivery of home and community based care has been conflictual by their own admission.

Pieterse (2001) argues that even though government has managed to cluster sectors at a Cabinet level, it has not transpired at departmental level and identifies this as one of the main reasons for well-developed and conceptualised policy interventions failing. The problem is complicated by the following institutional arrangements:

[16] The problem is compounded by the high illiteracy rates in poor communities often resulting in delays in the acceptance of business plans submitted by NGOs. To overcome the problem the DSD has allowed NGOs or communities submitting business plans to write in the vernacular language and then translate it into English. However, DSD officials expressed doubt at the capacity of the Department to support communities once the HCBC is operational at a national level.

- The geographical districts of the two departments do not correspond even though they are expected to follow a district approach and combine their services.

- They have different intradepartmental procedures for accessing and distributing funds.

- No effective intra and inter departmental referral system exists as yet. The PRP programme does not have adequate capacity to refer people to PRP projects in their communities and as yet no system exists for referring patients dismissed from hospital to HCBC support programmes.

Targeting for HIV/AIDS programmes

Without correct targeting, programmes can no do more but spread income (Everatt and Zulu, 2001). Accurate targeting in the case of HIV/AIDS is made difficult because of stigma associated with the disease. All respondents identified the unwillingness of infected and affected persons to make use of services because of fear of reprisal and isolation from the community.

The PRP based their projects in geographical locations with high infection rates to avoid the stigmitisation of individuals. However, the project management cannot be completely sure whether project participants are the correct target group, nor can members be denied participation in those projects. It is therefore not clear whether the funds benefit those they are intended for.

Furthermore, the PRP is unable to deal with the child-headed household phenomena. The project targets adults only. The child support grant is restricted to children younger than seven years, while the foster care grant involves a judicial process which could take up to two years. Many families headed by children could therefore be without any financial support This conflicts with the Department's strategy to support prevention by providing income support.

Limited priority given to CHBC

The South African government has to respond to the HIV/AIDS pandemic at a time when the public service is still in the process of transforming itself from its past apartheid structures, which encouraged unequal development and were only geared toward 10 percent of the country's citizens. This has led to the introduction of several new institutional arrangements, human resource strategies, and financial management systems at a time when the government has to deliver social services to the previously excluded majority in South Africa.

The introduction of the HCBC support programme and poverty relief programme is an example of the shift in policy to meet constitutionally mandated social welfare services *and* maintain fiscal discipline. The initial NIP objective was to pilot HCBC in six provinces in the first year, and then to roll it out to 3 more sites in the following year. The aim was to improve the programme before embarking on a nation wide programme.

However, due to great existing need, the projects had to expand. The NIP's targeted number for HCBC in 2000/2001 is 40, however, the model options accepted by parliament in February 2001 shows the revised target number of 200 HCBC teams for the current financial year. It is not clear how the costing of the programme will inform future allocations.

The primary focus of the NIP remains prevention. The low priority given to home and community based care (10%) is evident in the small allocation compared to the other two programmes.

However, given the limited funding allocated to HCBC, many problems were experienced in the disbursement of funds at national and provincial level in the previous financial year. The problems were attributed to lack of capacity at governmental and community level. Communities and Non-Governmental Organisations (NGOs) are expected to submit costed business plans to access funds. However, many of them do not have the capacity to develop business plans to the specification of administrative accounting rules. At a departmental level, the programme is plagued by lack of an interdepartmental funding mechanisms and intra and interdepartmental conflict. As shown earlier in this paper, the intended benefits of well-conceptualised policies have been hampered by inadequate funding and financial systems.

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Appendix A.

Questions contained in standardised questionnaire

- What are the key strategies for managing the HIV/AIDS epidemic within the programmes? What is the role of the programme in mitigating the impact of the disease?
- What are the main sources of funding for the HIV/AIDS programmes in national and provincial departments? What is the value of the allocations that have been made to these programmes? Preferably, data from the inception of the programme up to 2003/04)?
- How does the disease inform the allocation to the programme?
- What are the main disbursement mechanisms that are used to get the funds to the programme?
- What were the main obstacles that were experienced in the implementation of the HIV/AIDS programmes and funding?
- Recommendations that would make spending the resources more effectively and efficiently?

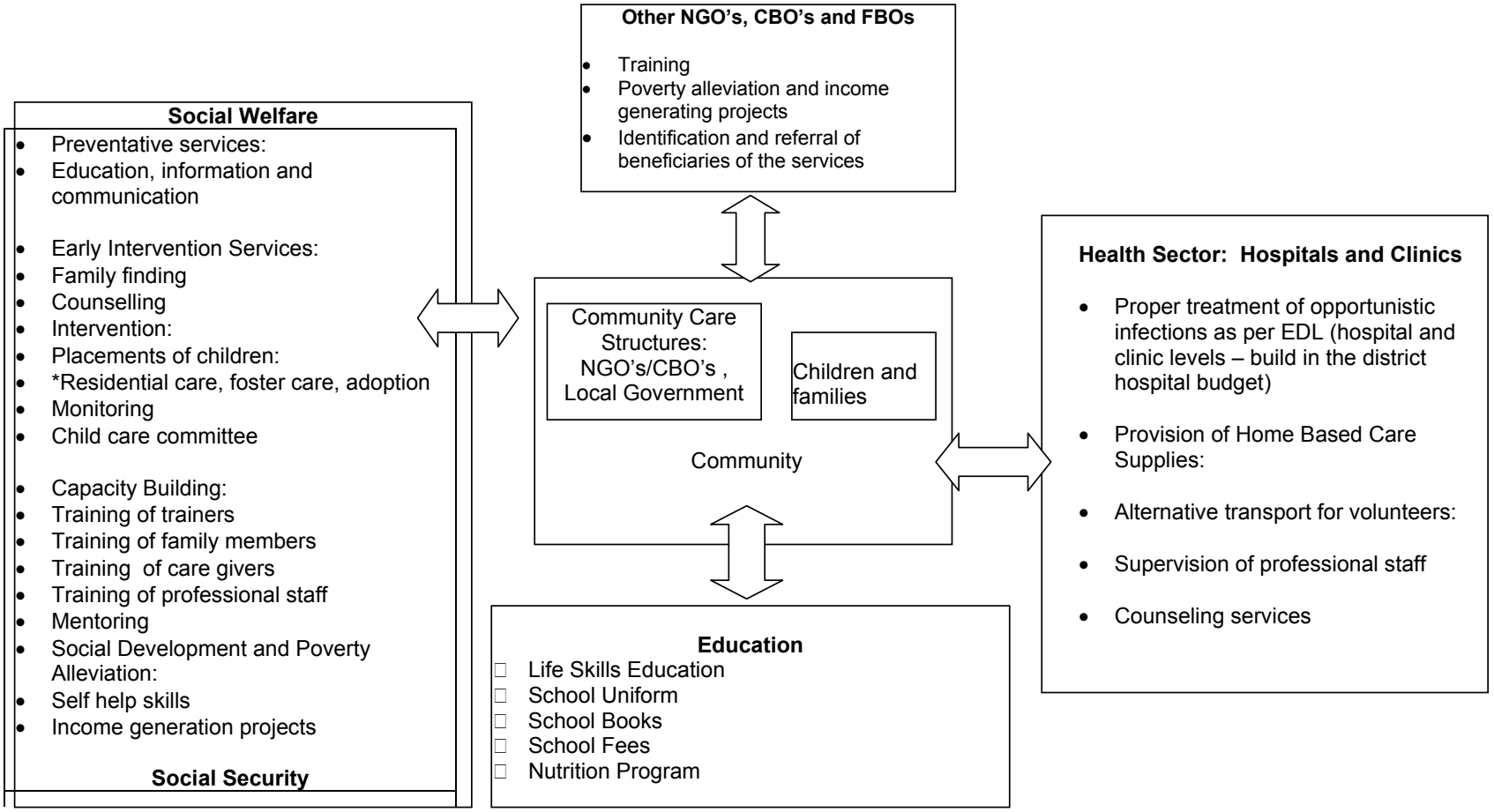
The sampling procedure was purposive in nature. The research process included:

- Face-to face interviews with people in the national and provincial DSDs who are responsible for co-ordinating the implementation HIV/AIDS projects in the different provinces;
- Briefings by government officials from the National HIV/AIDS Directorate presented to Idasa HIV/AIDS project members on the Department's response to the HIV/AIDS pandemic.
- Telephonic interviews with some of the people who are responsible for the implementation of the HIV/AIDS projects;
- Participation in an implementation plan workshop on CHBC and poverty relief for the DSD.

Appendix B.

Options for integrated home/community-based care models

OPTION 1: COMMUNITY DRIVEN MODEL



Appendix B. cont.

EXPLANATION OF THE COMMUNITY DRIVEN MODEL

In this model, the responsibility for providing home/community based care and support services is volunteer or community driven.

The community developer, who is responsible to liase and network with other partners, facilitates the process. This community developer could be from the religious sector, district/local government sector, business or a retired professional. Responsibilities of the community developer would be to co-ordinate the services, supervise and monitor the volunteer caregiver.

This model could be attached to a faith-based organisation or a non-governmental organisation within the community.

The community developer trains volunteer caregivers, who in turns support care givers within the family, i.e. the mother, father, brother, etc.

The community members can approach government departments such as Health, Welfare and Education as well as other donor agencies, in order to draw from their resources. Non-governmental organisations as well as Community Based organisations and Faith Based Organisations could also be approached.

Adequate provision of services and proper referral and networking between these different service providers are crucial

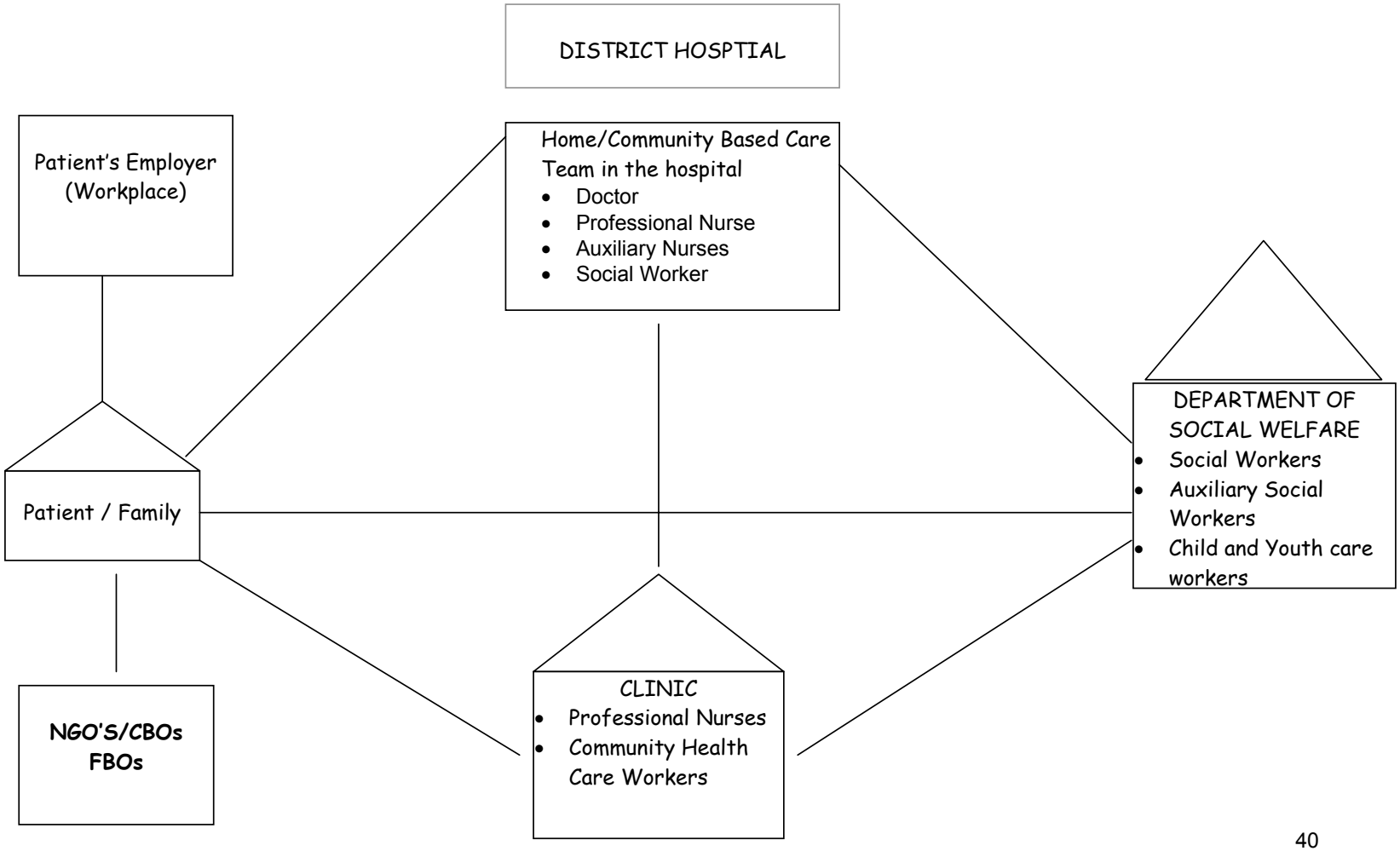
It is important that this model is based on an integrated service provision through locally driven initiatives.

RESPONSIBILITIES OF THE CAREGIVER IN THIS MODEL:

- Visit the patient and his/her family at home
- Identify the needs of the patient and his family
- Provide support, basic drugs, supplies and nutritional supplements where needed
- Assist in the referral to other levels of professional services, if needed.
- Community mobilisation
- Identify the children in need and refer them appropriately

Appendix B. cont.

OPTION 2: FORMAL GOVERNMENT SECTOR MODEL



Appendix B. cont.

EXPLANATION OF THE FORMAL GOVERNMENT SECTOR MODEL

In this model, the government departments such as health and welfare are spearheading the home/community based care program within the formal government sectors in collaboration with other partners.

A multi-disciplinary team, consisting of doctors, professional nurses, auxiliary nurses and social workers are driving the home/community based care program within the district hospital, with the full support and commitment of the superintendent.

After treatment in the hospital, the patient is discharged and reunited with his/her family and community.

Where possible, patients are being transported to their homes with transport provided by the hospital.

The patient and his/her family are referred to their local primary health care clinic for further follow-up treatment.

Home visits are conducted by the professional nurses as well as community health care workers to treat the patient at home.

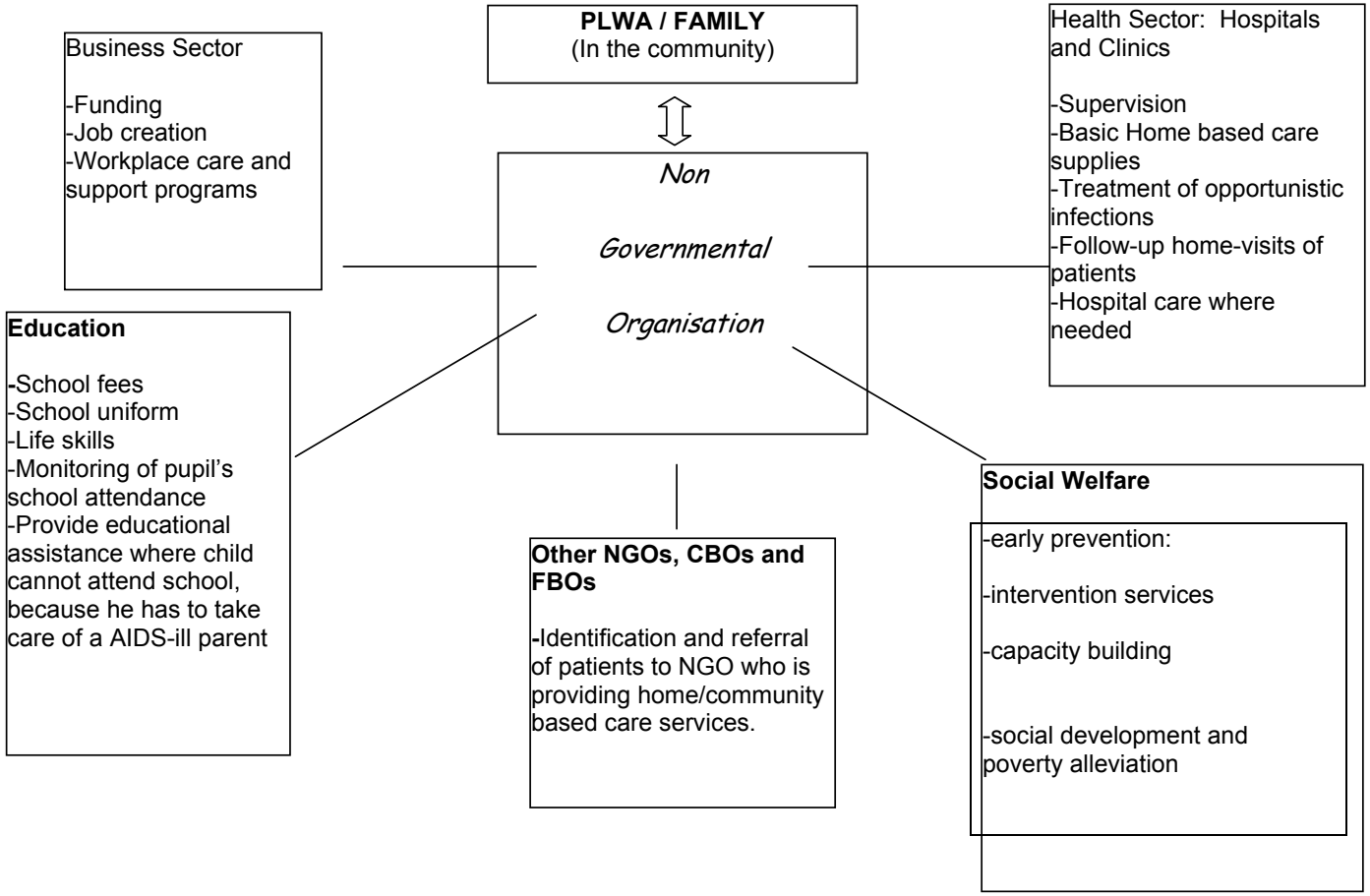
The clinic refers the patient back to the hospital, if further treatment at tertiary level is needed.

The social worker provides counselling and support services or refers the patient for application of a grant or other financial support services and community mobilisation.

NGOs, CBOs and FBOs assist the family and the patient with the necessary resources needed

Appendix B. cont.

OPTION 4: THE NON GOVERNMENTAL ORGANISATION HOME/COMMUNITY BASED CARE MODEL



Appendix B. cont.

EXPLANATION OF THE NGO HOME/COMMUNITY BASED CARE MODEL:

In this model, the responsibility of providing home and community based care services is given to a non-governmental organisation in the community. This organisation is responsible to identify the needs of the PLWA and his/her family

Services which is needed by the patient and his family are provided by this organisation.

The organisation act as a co-ordinating structure for services to the patient and his/her family and also network with other organisations in the community.

The entire home and community based care program is initiated by this organisation.

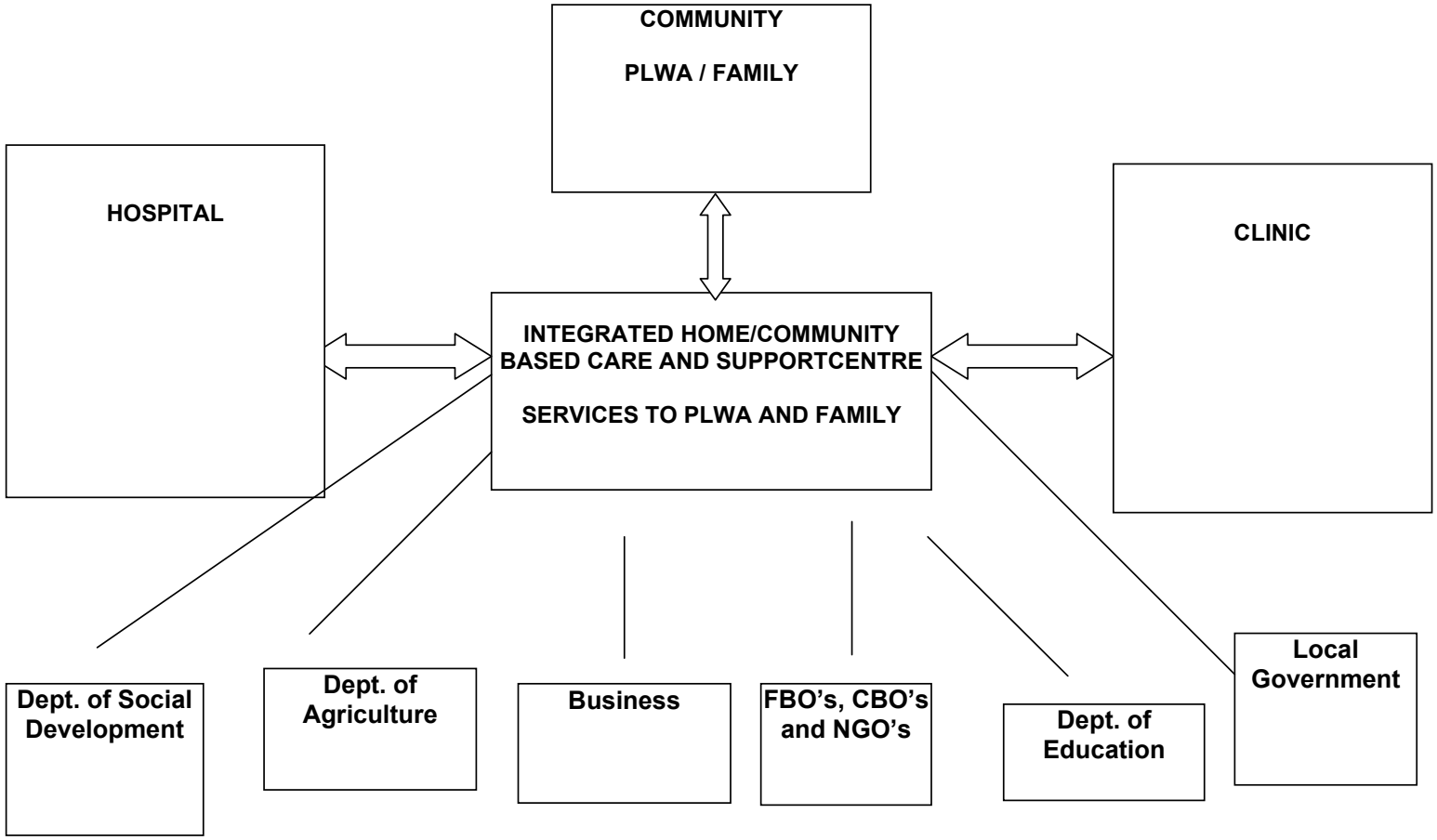
In order to ensure quality services to the patient, funding is made available to the organisation for administration, running costs, transport, salaries, stipends for volunteers, training, etc.

Other partners, such as Social Welfare, Health, Business, Education, etc, contributes towards the financial aspects of this organisation.

The services at the organisation will be provided by a team which consist of a professional nurse, social worker, project-co-ordinator and volunteers/community caregivers, based at the organisation

Appendix B. cont.

OPTION 3: INTEGRATED HOME/COMMUNITY BASED CARE CENTRE MODEL



Appendix B. cont.

EXPLANATION OF THE INTEGRATED HOME/COMMUNITY BASED CARE CENTRE MODEL

The home/community based care centre (drop-in-centre) is situated within the community and could be attached to a church or a school.

A project co-ordinator together with a team of volunteers manage the centre and ensure that quality home based care services are provided to the patient and his/her family.

The Departments of Health and Welfare could second a professional person to the centre, which could provide professional services at the centre. The centre could act as a co-ordinating structure for home based care services.

In order to sustain the centre, funding is needed for administration, transport, staff salaries, stipends for volunteers, running costs, etc.

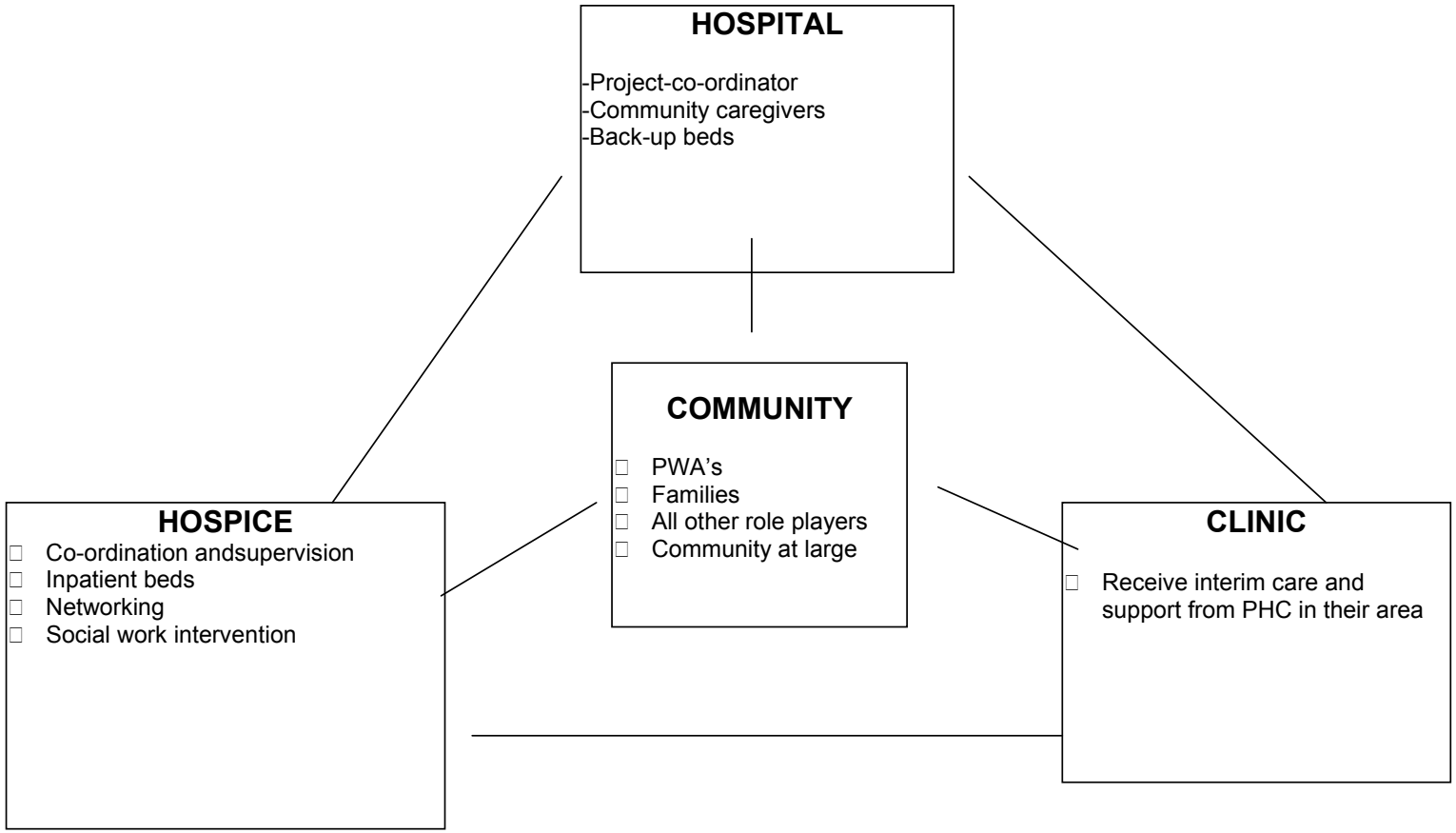
Activities at the centre includes the following: Pre-and post test counselling, HIV-testing, training of family members and community care givers (volunteers), distribution of IEC materials, income generating projects, supervision and monitoring of community care givers, conducting of home visits and patient follow-ups.

The centre could also act as a Halfway House and Day care centre

Referral to and from hospital and clinic as well as to other service providers can take place at the centre

Appendix B. cont.

OPTION 5: HOSPICE – INTEGRATED COMMUNITY HOME CARE MODEL



Appendix B. cont.

EXPLANATION OF THE HOSPICE MODEL

This is an integrated community based HIV/AIDS home care model which aims to provide a continuum of care which includes counselling and support of well people with HIV while placing emphasis on palliative care.

Components of this model:

Community Care giver Team:

Each team comprises of two carefully selected and formally trained community caregivers (CCG), a means of transport and basic equipment

Training as per Hospice Association of South Africa (HASA) curriculum training is holistic and ongoing

Paid volunteers: Volunteers from disadvantaged areas are usually unemployed persons looking for a job. It therefor makes profound sense to select people for their suitability and pay them a normal salary. Compassion is not dependent on socio-economic status and community caregivers have much in common with their more affluent traditional Hospice volunteer first world counterparts.

Appendix C.

Conditional Grant Expenditure Per Province for 2000/2001

Mpumalanga	R960 000	The province supports 34 HCBC projects. The province identified and assisted the following number of children: Masoyi home based care: 500 Thembalethu home based care: 1 110 Thembalithle home based care: 206 **Total number of children assisted: 1 816**
Northern Cape	R 1000 000	The number of children identified and assisted: Namaqualand Region:188 Upington Region: 211 Diamond Fields Region: 86 Most children have been placed in foster care and others adopted. **Total number of children assisted: 485**
Northern Province	R800 000	Food parcels were provided to families at R225 per month per family of 5. The rest of the funds were used to buy schoolbooks, uniforms and pay school fees. Volunteers were trained and Faith Based Organisations are being involved. **Total number of children assisted: 1120**
North West	R 1000 000	The province has engaged the services of an NGO, Life Line, to manage the HIV/Aids programme in Joubert, Klerksdorp. **A total of 110 needy families have been identified and will each receive material support to the value of R510 per family**

Appendix D.
Cost of Implementing the CHBC programme

ABT associates (2000) estimated that, without any changes to the current patterns of care, the total number of hospital admissions will increase to over 2 million by 2010 (Ibid,2001). However, they estimated that once fully implemented, the CHBC model would result in a reduction of 30% of hospital bed days, saving the state millions of rands. CHBC also has cost-saving implications for provincial DSDs. It is estimated that South Africa could have approximately 2.2 million orphans (South African Child Welfare Council, 2000) by the end of the decade. A large number of children would be in need of residential care in the absence of other care options. The community care "model" could therefore provide a more cost efficient means of delivering on statutory mandated services pertaining to the right of the child to shelter.

If the CHBC programme is to be successful and comprehensive in its coverage, 200 teams must be established by March 2002 and 400 teams per annum in the following years. The target is 2400 teams nationally by 2010/2011. Each team will consist of the following core group of people:

Comment: According to ABT??

- 1 x Team manager/co-ordinator (full time) - Must be a professional on the level of a senior professional nurse or senior social worker.
- 1 x Child and youth care worker (R 1200 p.m.)
- 1 x Professional nurse (part time)
- 8 x Community care giver (R500 or R1000 p m)
- 1 x Childcare forum(voluntary)
- Core team = 10 people plus childcare forum members who act as volunteers

Table 1 sets out the annual cost of operating one CHBC team at stipend levels of R500 or R1000 levels respectively. Table 2 illustrates the cost components of a single CHBC team as envisaged under the model, including the one-off set-up costs required to establish the team in 2001 prices at stipend levels of R500. Table 3 estimates the start up cost of one team to be R322,00 and the recurrent cost R556,097(personnel and non-personnel costs)per annum.

Table 1: Costs per team at different stipend level:

Stipend level for community care giver:	Annual Recurrent Cost (Rand)
R 500	556,097
R 1,000	604,097

Source: Ibid, 2001

Table 2 : Operating Costs of One CHBC Team and Support Services
Stipend = R500 per month

Set-Up Costs	(One off)	Personnel	(Annual)	Non-Personnel	(Annual)
Equipment		*Core Team*		*Admin & Transport*	
Computer equipment	40,000	1 x Manager	106,805	Phone & Fax	9,600
Fax machine	5,000	Child & Youth Care Worker	14,400	Vehicle maintenance	12,000
Photocopier	8,000	Admin. Worker	14,400	Fuel	6,000

Vehicle	131,000	8 x CCGs (R500 per month)	48,000	License	200
		10 x Child Care Cttee members (R250)	30,000	Insurance	3,600
Training				Bus & Taxi fares	21,600
Manager (10 days x R500)	5,000	*District Support*		Premises (rent / maint /rates)	41,400
8 CCGs (59 days x R250)	118,000	0.5 x Professional Nurse	44,800	Community meetings	13,000
Child & Youth Care Worker	5,000	0.5 x Social Worker	53,402		
Child Care Committee members	10,000			*Materials*	
				HBC supplies	30,190
				IEC materials	25,000
				Fund	
				Self-help / income generation	43,200
				Training	
				In-service training / refresher	9,000
				Attrition replacement	29,500
Set-Up Sub-Total	322,000	Personnel Sub-Total	311,807	Non-personnel Sub-Total	244,290

Set Up Costs 322,000
Annual Operating Cost 556,097

Source: Ibid, 2001

Total costs can be estimated using a needs-based or population-based approach. The needs-based approach is based is based on *the likely trends* in the *progression of the disease*, *and the pattern of the disease progression seen in affected individuals).* The population-based approach is designed to provide population coverage for a defined community. The DSD estimated that each team would have to serve approximately 17 000 people under the population-based approach *(*Ibid, 2001).

Table 3 shows that provincial Health and DSDs will have to spend 120 million in the current financial year and R574 and R694 million respectively by 2003/2004 to operationalise the CHBC programmes assuming R500 stipend and the need-based or population approach (see Table 4).

Table 3: Total Costs – All Scenarios[17] (Millions of Rands)

R million	Needs based approach		Population based approach[18]	
	With R500 stipend	With R1000 stipend	With R500 stipend	With R1000 stipend
2001/02	120	125	120	125
2002/03	351	370	351	370
2003/04	574	612	694	737
2004/05	706	760	1,027	1,099
2005/06	815	880	1,361	1,462
2006/07	896	970	1,335	1,450
2007/08	980	1,060	1,335	1,450
2008/09	1,045	1,132	1,335	1,450
2009/10	1,088	1,180	1,335	1,450
2010/11	1,129	1,225	1,335	1,450

Source: Ibid, 2001

[17] The estimated cost excludes the cost of school uniforms, food parcels etc.

[18] The population-based approach also requires the ultimate target to be reached faster, with the effect that its costs accelerate faster and then level off.

Appendix D.

Current value and eligibility criteria of the grants

Grant type	Value, R per month	Eligibility criteria
Old age pension	540 570 from July 2001	To qualify, a man must be 65 or over and pass a means test and a woman must be over 60 and pass a means test.
Disability	540 570 from July 2001	To qualify, a person needs to be over 18 (less than 60 years if a women and less than 65 if a man), pass a means test and be certified by a medical doctor as incapable of working.
Child support	100 110 from July 2001	To qualify, the care-giver of a child age 0-6 must pass a means test and supply his/her ID book and the child's birth certificate. A maximum of 6 grants per care-giver is permitted.
Foster	390 410 from July 2001	To qualify, a court order placing the child in the care of the foster parent(s) is required. Applicants are not means tested, as the grants are not poverty related, but the child's income is taken into account. Grants are paid for care of a child 0-8 years, or 0-21 years if the child is still in secondary school. Only 6 grants per foster parent(s) may be obtained.
Care dependency	540 570 from July 2001	To be eligible a child must be certified in need of full-time care, be 0-18 (excluding 18) or to 21 years if a child is still in secondary school. The grant can be accessed by foster or biological parents.

Appendix E.

Provincial actual expenditure for 2000/01 and estimates of expenditure for 2001/02-2003/04 on the five main grants

Child Support Grant

Table 4a: Actual and budgeted expenditure on the child support grant, Rands (nominal)

Province	2000/01	2001/02	2002/03	2003/04	2000/01-2003/04
MPA	93387000	147757000	231655000	260624000	179
KZN	241031000	345982000	444895000	761596000	215
WC	56016000	75276000	90000000	90000000	60
NW	95408000	105771000	120324000	126973000	33
GAUT	112565780	190512646	288621138	408775134	263
NP	154534023	271710000	450000000	450000000	191
FS	42503720	78132000			
NC	17210519	31416376			
					156.8

Foster care grant

Table 5: Actual and budgeted provincial expenditure on the foster grant (nominal)

Province	2000/01	2001/02	2002/03	2003/04	2000/01-2003/04
MPA	11149000	10931000	11975000	17316000	55.3
KZN	39855000	44609000	55609000	64609000	62.1
WC	110000000	95986000	102335000	111064000	1
NW	18406000	20427000	23237000	24521000	33.2
GAUT	61569692	65484228	70484840	75568126	22.7
NP	17344751	24937100	38000000	60000000	245.9
FS	34265271	24055000			
NC	27278437	28968369			
					70.0

Care dependency grant

Table 6: Actual and budgeted provincial expenditure on care dependency grant(nominal)

Province	2000/01	2001/02	2002/03	2003/04	2000/01-2003/04
MPA	8686000	7707000	9741000	11689000	34.5
KZN	61832000	88770000	122848000	141848000	129.4
WC	11000000	24616000	31004000	33243000	202.2
NW	13935000	15458000	17585000	18557000	33.1
GAUT	16765738	20101066	31671629	42568126	153.8
NP	21591419	30971250	51000000	81000000	275.1

FS NC	6542422 4306290	6411000 5840969			 138.0

Old Age Pension

Table 7: Actual and budgeted provincial expenditure on the old age pension (nominal)

Province	2000/01	2001/02	2002/03	2003/04	2000/01-2003/04
MPA	870763000	910357000	987454000	1017232000	16.8
KZN	2528723000	2620104000	2951019000	3087271000	22.0
WC	924267000	1013329000	1099459000	1191611000	28.9
NW	1042504000	1155864000	1314907000	1387563000	33.0
GAUT	1446862531	1526504852	1604179192	1668068250	15.2
FS	721589729	769967000			
NC	268309919	287516159			 23.1

Disability Grant

Table 8: Actual and budgeted provincial expenditure on the disability grant(nominal)

Province	2000/01	2001/02	2002/03	2003/04	2000/01-2003/04
MPA	231722000	226204000	231869000	236716000	2.1
KZN	848880000	876013000	974085000	999863000	17.7
WC	597521000	624512000	663347000	720140000	20.5
NW	383990000	426373000	485040000	511841000	33.2
GAUT	397408166	450295140	484571627	531203830	33.6
FS	212297978	234675000			
NC	200851015	209574078			 21.4